3-0900-20500-2

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE COMMISSIONER OF HEALTH

In the Matter of Rose of Sharon Manor; Survey Exit Date March 6, 2009

RECOMMENDED DECISION

The above matter was the subject of an independent informal dispute resolution (IIDR) conducted by Administrative Law Judge Kathleen D. Sheehy on June 30, 2009. The OAH record closed at the conclusion of the conference that day.

Marci Martinson, IIDR Coordinator, Licensing and Certification Program, appeared on behalf of the Department of Health's Division of Compliance Monitoring (Department). Mary Cahill, Planner Principal with the Division of Compliance Monitoring, also participated in the conference.

Amy Wiffler, Regional Director of Operations, Extendicare, 1000 Lovell Avenue, St. Paul, MN 55113, appeared without counsel on behalf of Rose of Sharon Manor. Sarah Anderson, Program Director, Psychiatric Recovery Senior Services, also participated on behalf of Rose of Sharon Manor.

FINDINGS OF FACT

1. In March 2009, the Department of Health's Office of Health Facility Complaints (OHFC) conducted a standard survey at Rose of Sharon Manor in Roseville, Minnesota.

2. On or about March 6, 2009, the OHFC issued a Summary Statement of Deficiencies to the Facility, citing a violation of Tag F 319 (quality of care, mental and psychosocial functioning) as a G-level deficiency, concluding the deficiency was isolated in scope with a severity level of actual harm that is not immediate jeopardy.[1]

3. In this IIDR proceeding, the Facility disputes the citation and asserts that it should be removed.

Resident #95

4. Resident #95 is a 69-year-old man who was admitted to the Facility on July 22, 2008, for the purpose of receiving rehabilitative physical and occupational therapy after being hospitalized for an episode of congestive heart failure. The resident also had a lengthy history of alcohol dependence and had

[1] MDH Ex. D.

some impairment of short-term memory.[2] Before his hospitalization, the resident had lived independently with a long-term partner in an unkempt apartment. He had been estranged from his family for many years. His sister, with whom he reconciled during his hospitalization, anticipated that the resident would no longer be able to live independently and that upon completion of therapy the resident would be discharged to an assisted living facility.[3]

5. The Facility has a policy to provide a distinct short-term care unit for patients anticipating a stay of 90 days or less. The West Wing of its building is the designated Short-Term Unit for transitional patients.[4] Most residents on the West Wing are in relatively good health and are preparing for eventual discharge to their homes. Because the resident's stay was expected to last about three weeks, the resident was admitted to a bed on the West Wing.[5]

6. The resident made progress in therapy and responded well to the environment. The resident's sister continued to search for an appropriate assisted living facility, with assistance from the social services worker.[6]

7. By October 2008, it was becoming apparent that the resident's criminal history and the need to have an appropriate agency screen and approve him for waivered services were complicating efforts to find an assisted living placement. While these efforts continued, the resident remained on the West Wing.[7]

8. As of October 24, 2008, the resident's stay had been uneventful. He enjoyed smoking outside and socialized to some extent with his roommate and other residents who used the outdoor smoking area. There was no indication that his mood or his behavior were worsening.[8]

9. On December 3, 2008, the resident was moved from the West Wing to a long-term care floor on the East Wing. Social services notes reflect that although the resident was still planning to be discharged, his discharge was taking longer than expected. The resident was placed in a room near the exit to the outdoor smoking area. The resident consented to this move. The social services worker anticipated, however, that the resident "may experience some complaints with his new room due [to] the fact that there are a few 'screamers' close by." The social services worker indicated he would continue to follow up with the resident to see how the resident adjusted to the new room.[9]

10. Within one week, the resident was "experiencing some unhappiness" as a result of the room transfer. The resident was not happy with

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[2] MDH Ex. D-2.
[3] Ex. D-2; Letter from Sarah Anderson to Susanne Reuss (Mar. 11, 2009).
[4] Rose of Sharon Manor Short-Term Care Unit Designated: West Wing (Policy Dated Feb. 2008).
[5] Social Services Progress Note (7/23/08).
[6] *Id*. (8/8/08 and 9/15/08).
[7] *Id*. (10/24/08).
[8] *Id*.
[9] *Id*. (12/3/08).

the increased noise from other nearby residents, and he had become more gruff with the staff.[10]

11. By January 7, 2009, nursing staff had noted concerns with the resident since the room transfer. Nurses believed that he was becoming more isolated, leaving his room less often to smoke or eat meals. He was unhappy with the snoring by his roommate and with some of the "noisemakers" who resided nearby. When social services met with the resident, the resident appeared to assume that he would be moved to a different room. The social services worker informed him that the facility was "attempting to look at a few other options, but nothing [was] available."[11]

12. On January 11, 2009, an assessment of the resident's mood revealed indicators of depression, anxiety, and sadness, with persistent anger with self or others and reduced social interactions.[12]

13. On January 13, 2009, the resident spit chewing tobacco at a nursing assistant. The social services worker referred the resident to a psychotherapist to address his complaints about being at the facility and about the other residents around him.[13]

14. A psychotherapist met with the resident on January 14, 2009. She diagnosed an adjustment disorder with depressed mood. The resident told her he felt out of place at the nursing home and was easily angered about his surroundings (noise, other residents, etc). He was fearful that he would live there for the long term and that his cognitive abilities would decline. He was very agitated about the noise of other residents and the noise associated with the exit door to the smoking area. He was wearing earplugs to deal with the noise. The psychotherapist believed that a room change would likely cause short-term improvement in his mood. She recommended that the resident be more involved with discharge planning efforts and that a room change be made, if possible, to a more quiet area away from the traffic associated with the exit door.[14]

15. On January 21, 2009, the resident's care plan was revised in response to this assessment. The care plan provided that the resident "has a lot of mood indicators related to a recent room transfer." It also noted that the resident "tends to get upset with some of the other folks." The interventions added to the care plan included monthly psychotherapy and "social service will attempt to visit with resident to help problem-solve some potential options including possible room transfers."[15]

[10] Social Services Progress Note (12/10/08).
[11] *Id*. (1/7/09).
[12] Ex. D-2.
[13] Social Services Progress Note (1/13/09).
[14] Psychiatric Recovery Senior Services Diagnostic Assessment (1/14/09).
[15] Mood and Behavior Symptom Assessment/Plan of Care (1/21/09).

16. As of January 28, 2009, the facility was continuing to explore the option of a room change, but there were no open rooms for men on the long-term wings, and no other residents would agree to exchange rooms with him.[16]

17. On February 11, 2009, the resident's roommate was discharged from the facility, and the resident was moved to the roommate's former bed by the window of the same room.[17] The same day, he had a second therapy session in which the therapist noted his appearance was unkempt, his mood was anxious and mildly depressed, and he was preoccupied. She also noted that his mood had improved since some progress had been made to move him to an assisted living facility. She wrote that his sorrow and fears associated with remaining in the nursing home have decreased because he now viewed placement as temporary.[18]

18. On March 2, 2009, the resident spoke to a surveyor and voiced many concerns about his environment. He told the surveyor that he was very unhappy about the noise created by the location close to an exit door and the ongoing hollering of a resident living in the adjoining room. The surveyor confirmed that the neighboring resident was loud, boisterous, and difficult for staff to control. The surveyor observed that the resident was eating meals and watching television in his room instead of common areas.[19]

19. On March 6, 2009, the facility's administrator acknowledged that other rooms were available on the West Wing, but not on the long-term care floors. She stated that according to facility policy, the West Wing was a short-term unit, and after 90 days residents had to be moved off that unit. She said "there was no place else to put him, if we move him back to the west wing we would have other people upset." She indicated that if this resident was moved to a more desirable room on the West Wing, other residents might seek a similar move ("What you do for one you have to do . . . for everyone").[20]

20. Based on interviews and record review, the Division concluded that the Facility failed to provide the necessary care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on these findings, the Department issued Tag F 319 (quality of care), which alleges a violation of 42 C.F.R. § 483.25(f)(1).

21. On March 17, 2009, and March 30, 2009, the Facility offered the resident the opportunity to move to a different room on the same long-term care floor. The resident declined the opportunity to move. The neighbor he had found to be disruptive was no longer residing in the facility, and the resident did not see any need to change rooms at this point.[21]

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[16] Social Services Progress Note (1/28/09).
[17] *Id*. (2/11/09).
[18] Psychotherapy Note (2/11/09).
[19] Ex. D-2.
[20] Ex. D-5.
[21] Social Services Progress Notes (3/17/09 and 3/30/09).

22. On April 26, 2009, the resident was discharged to an assisted living facility.

Based upon the exhibits submitted and the arguments made and for the reasons set out in the Memorandum that follows, the Administrative Law Judge makes the following:

RECOMMENDED DECISION

Tag F 319 is supported by the facts and should be affirmed.

Dated: July 7, 2009.

s/Kathleen D. Sheehy
KATHLEEN D. SHEEHY
Administrative Law Judge

Reported: Digitally recorded (no transcript prepared).

NOTICE

In accordance with Minn. Stat. § 144A.10, subd.16(d)(6), this recommended decision is not binding on the Commissioner of Health. As set forth in Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the Facility indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge within 10 calendar days of receipt of this recommended decision.

MEMORANDUM

Tag F 319 is based upon an alleged violation of 42 C.F.R. § 483.25(f)(1). Section 483.25(f)(1) requires that, based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.[22] In issuing the tag, the Department found that the Facility had failed to implement the appropriate interventions related to the factors causing the resident's psychological distress: the noisy neighbor, and the delay in placement at an assisted living facility.[23]

The record clearly reflects that the resident's mood and behavior changed for the worse in response to the room change. Nursing staff noted concerns with his increasing isolation, and an assessment of his mood in early January 2009 disclosed depression, anxiety, sadness, and anger that had not existed in earlier assessments. Because of these changes, the Facility appropriately arranged for

[22] 42 C.F.R. § 483.25(f)(1).
[23] Ex. D-6.

the resident to see a psychotherapist, who recommended in part that a room change be made "if possible" to a more quiet area. The psychotherapist believed that this change would likely cause short-term improvement in the resident's mood by increasing his sense of control over his environment and his optimism about the possibility of discharge.

The Facility contends there was no deficient practice, because it provided all appropriate treatment and services to the Resident: It provided him with earplugs for the noisy neighbor, it moved him to the bed near the window in his room, and it provided him with psychotherapy services and encouragement to participate in discharge planning so that he would be motivated to view his stay there as temporary. What the Facility failed to do, however, was to implement the specific recommendation made by the therapist, which was incorporated into the care plan, to change the resident's room if possible in order to improve his mood. There were no alternate rooms available on the long-term care floors; however, there were rooms available on the short-term unit. The Facility conceded that the rooms in the two wings are subject to the same licensing standards and that there is no difference in the cost of the rooms or in the services provided by staff members. There was no therapeutic reason why the resident needed to be in the East Wing versus the West Wing; rather, the decision not to move the resident to an open room on the West Wing was based on the Facility's desire to enforce its policy reserving rooms in the West Wing for short-term residents, at the expense of the individualized mental health needs of this resident. This is a failure to implement an appropriate intervention related to one of the factors causing the resident's psychological distress, and it is the deficient practice demonstrating violation of 42 C.F.R. § 483.25(f)(1).

At the IIDR meeting, the psychotherapist maintained that the resident had become frustrated while living on the West Wing because he saw others being discharged, while he was required to remain at the facility because of the unexpected delay in finding an alternative placement. She stated that she would not have recommended moving him back to the West Wing because it would have exacerbated his sense of frustration at remaining in the facility, particularly since it appeared he might have to reconcile himself to being there for the long term. These opinions are not reflected in any of her therapy notes (or any other records relating to the resident) and appear to be inconsistent with her recommendation that the resident be more fully involved in planning for discharge in order to increase his optimism about his future.

The State Operations Manual instructs surveyors that the presence of a psychosocial problem (whether behavioral or mood-related) does not necessarily indicate an outcome that is the direct result of noncompliance. Because many nursing home residents have sadness, anger, or loss of self-esteem in reaction to normal life experiences, the survey team is required to determine whether a given psychosocial outcome is a result of the facility's noncompliance. Psychosocial outcomes of interest to surveyors are those caused by the facility's

noncompliance with any regulation, including outcomes resulting from the facility's failure to assess and develop an adequate care plan to address a resident's pre-existing psychosocial issues, which led to continuation of or worsening of the condition. Surveyors are instructed to compare the resident's behavior and mood before and after the noncompliance. If noncompliance has resulted in a negative psychosocial outcome, surveyors must determine the severity of the outcome.[24] "Actual harm" is demonstrated if the facility's noncompliance resulted in a negative outcome that has compromised the resident's ability to maintain and/or reach his/her highest practicable physical, mental, and psychosocial well-being, as defined by an accurate and comprehensive resident assessment, plan of care, and provision of services. A lesser rating could be appropriate when there is no actual harm, but there is potential for more than minimal harm that is not immediate jeopardy.[25]

The resident's care plan was revised on January 21, 2009, to include the recommendation with regard to room transfer. On February 11, 2009, the resident's therapy record notes he was still unkempt, anxious, mildly depressed, and preoccupied. She noted that his mood had improved "somewhat" since progress had been made to move him to an assisted living facility and "he now views placement as temporary." Approximately one month later, the resident made it clear to surveyors that he was still very unhappy about the location of his room near the exit door and the noise made by the difficult neighbor next door. He was still isolating himself by eating meals and watching television in his room instead of common areas. At minimum, the record reflects that the resident's psychosocial problems continued from January 21, 2009, through the time of the survey and that despite incremental improvement in his mood due to therapy and progress made in discharge planning, his mood may well have improved even more if the facility had followed the therapist's recommendation and changed his room location.

After careful consideration of the record, the Administrative Law Judge concludes that the Division has demonstrated that the citation is supported by the facts and should be affirmed.

K.D.S.

[24] Ex. C-4.
[25] Ex. C-2.